

** This form applies only to the ARRA Premium Reduction **
PARTICIPANT NO LONGER ELIGIBLE FOR REDUCED PREMIUMS

Instructions: Use this form to notify your former employer that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

Send completed form to: [insert Employer contact name and address]

PERSONAL INFORMATION

Name and mailing address	Telephone number
	E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below.	<input type="checkbox"/>
Insert date you became eligible _____	
I am eligible for Medicare.	<input type="checkbox"/>
Insert date you became eligible _____	

IMPORTANT

If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

Signature of employer responsible for COBRA administration for the Plan under ARRA

Date

Group ID#